(2) that the status lymphaticus which was present is essentially connected with the distorted and intensified type of illness. McNeil describes anaphylaxis as a bodily condition in which abnormal reactions follow repeated injection of a substance which at first injection produced no apparent disturbance of health. Under clinical examples of general anaphylaxis he mentions serum disease, with its ordinary accelerated and immediate reactions, food anaphylaxis such as urticarias and edemas, pollen asthma as in hay fever and acute infectious diseases, the smptoms of onset of which Von Pirquet, Schick and others regarded as anaphylactic. McNeil emphasizes that both in the ordinary and the fulminant pneumonia the symptoms of onset are anaphylactic. Under clinical examples of local anaphylaxis the cutaneous and conjunctival tuberculin reactions are cited and the author submits that in the local reactions of scrofula we have an exaggerated form of local anaphylaxis, similar to the general anaphylactic reaction in fulminant pneumonia. These alleged instances of clinical anaphylaxis are similar pathologically accepted instances of anaphylaxis whose leading pathological features are vasomotor paresis, constriction of certain types of non-striped muscle, edema of the loose connective-tissue, destruction of the more delicate body epithelia and the production of these changes by very small doses of virus. The pathological similarity is here described separately and in detail using fulminant pneumonia and scrofula as examples. Discussing the weakness of the virus the disproportion of cause and effect is seen in human anaphylaxis, as in the sting of an insect or the local reaction by tuberculin or by the tertiary stage of syphilis, of which McIntosh says," the extensive lesions without Spirocheta pallida in any number must be due to minute quantities of syphilitic toxin on highly sensitized tissues." The author claims that in fulminant pneumonia the virus is weak because of the great number of similar non-fatal cases also observed and that the fatal issue was due to hypersensitive condition of the body (anaphylactic) and not to a virulent poisoning. As to scrofula, the ordinary, normal reaction of tuberculin is accepted as an anaphylactic reaction; the intense reaction in scrofula is heightened anaphylaxis. In these various features, then, of fulminant pneumonia and scrofula, which show evidence, not of intensification of the virus, but of intensified reaction to the virus, the special stamp of pathological histology and physiology is identical with that of the phenomena of anaphylaxis, both experimental and clinical.

Empyema in Children.—H. G. MELVILLE-DUNLOP (*Edinburgh Med. Jour.*, 1914, xiii, 4) gives an analysis of 98 cases of empyema in children. During the period covering these cases 861 cases of pneumonia were treated, making a proportion of one case of empyema to every 8 or 9 cases of pneumonia treated on a childrens' ward. Almost all effusions in the pleura of children under three years are of a purulent character. The liability to purulent effusion lessens from three to ten years when the tendency to serous effusion is usually established. In 79 cases under ten years, 68 were purulent; in 67 cases at ten years and over, 28 were purulent. The pneumococcus was present in pure culture in 53 per cent. of all the cases, giving pus of an opaque, greenish color, of creamy consistence and with large masses of fibrin.

Streptococcal infection came next in 16 per cent., and caused a much thinner pus with a whitish-gray deposit on standing. Mixed infection with pneumococcus and streptococcus occurred in 14 per cent. of cases. The staphylococcus alone was present in 3 per cent. of cases. The tubercle bacillus occurred in 3 per cent. of cases, but being hard to find the percentage is probably slightly higher. The fluid in the latter cases was of a turbid character. Dunlop believes that primary forms of empyema are exceptional. In only 7 per cent. of this series was there no history of an antecedent cause for the empyema. The effusion generally occurred with, or followed lobar pneumonia and was invariably purulent. It was much less frequently associated with bronchopneumonia, but frequently developed subsequently to the infectious diseases as scarlet fever, etc. In most of the cases the effusion occurred within a few days of the crisis of a pneumonia. Empyema is often overlooked and the case treated as one of atrophy or miliary tuberculosis. It should be a routine practice to examine from time to time every case not making satisfactory progress. The symptoms of the advent of empyema are usually fever, cough, vomiting, quick breathing, sweating, restlessness, and delirium. Languor, a short paroxysmal cough and rapid emaciation are more especially the symptoms in older children. Especially, the child in almost every case looks seriously ill, has an anxious, pinched appearance and is profoundly anemic. Dyspnea, as found in pneumonia does not usually occur. Leukocytosis is usually from 20,000 to 30,000. Absolute, boardy dullness at the base with a boxy percussion note at the apex and harsh exaggerated breathing above the dullness is very suspicious of pleural effusion. Loud tubular breathing is common over a purulent effusion. The commonest complication was purulent pericarditis present in 40 per cent. of the fatal cases. Exploratory puncture is frequently necessary and is attended by little risk. Under two years the prognosis is grave but after two years the mortality diminished. Pneumococcal cases over two years usually recovered but in streptococcal and mixed cases the prognosis was not so good. Early evacuation and drainage is imperative if good results are to be looked for. Where the fluid is only turbid or the infant very young and unable to stand a serious operation aspiration is best used.

Pyloric Obstruction in Infants.—C. H. Miller (*Lancet.*, 1914, clxxxvii, 987) discussed a series of 9 cases of pyloric obstruction in infants. The ages varied from sixteen days to eighteen weeks. There were three deaths, two from intercurrent conditions and of the six recoveries five have become perfectly normal children. Sudden, forceful vomiting is characteristic. In these cases it was noteworthy that if peristalsis was violent the treatment was much easier and progress steadier. Peristalsis is a variable sign. Visible peristalsis may occur without any hypertrophy of the stomach. It should be regarded as a sign of obstruction rather than of hypertrophy. Peristalsis of the stomach is seen also in infants with vomiting and colic in which the condition is satisfactorily treated by castor oil and eliminating milk curd from the diet for a few days. These are instances of "pyloric spasm." The presence of a palpable pyloric tumor Miller is rather skeptical of,